MEDI-CAL UPDATE Part 2
Billing and Policy
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Inpatient Services

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Contents

2006 CPT-4/HCPCS Updates: Implementation November 1, 2006

The 2006 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after November 1, 2006. The affected codes are listed below. Only those codes representing current or future Medi-Cal benefits are included. Please refer to the 2006 CPT-4 and HCPCS Level II code books for complete descriptions of these codes. Specific policy, billing information and manual replacement pages reflecting these changes will be released in a future *Medi-Cal Update.*

CPT-4 Code Additions

Anesthesia
01965, 01966

Surgery
15040, 15110, 15111, 15115, 15116, 15130, 15131, 15135, 15136, 15150, 15151, 15152, 15155 – 15157, 15170, 15171, 15175, 15176, 15300, 15301, 15320, 15321, 15330, 15331, 15335, 15336, 15340, 15341, 15360, 15361, 15365, 15366, 15420, 15421, 15430, 15431, 22010, 22015, 22523 – 22525, 28890, 32503, 32504, 33507, 33548, 33768, 33880, 33881, 33883, 33884, 33886, 33889, 33891, 33925, 33926, 36598, 37184 – 37188, 37718, 37722, 43770 – 43774, 43848, 43886 – 43888, 44180, 44186 – 44188, 44213, 44227, 45395, 45397, 45400, 45402, 45499, 45990, 46505, 46710, 46712, 50250, 50382, 50384, 50387, 50389, 50592, 51999, 53850, 57295, 58110, 61630, 61635, 61640 – 61642, 64650, 64653

Radiology
75956 – 75959, 76376, 76377, 77421 – 77423

Pathology and Laboratory
80195, 82271, 82272, 83631, 83695, 83700, 83701, 83704, 83900, 83907 – 83909, 83914, 86200, 86355, 86357, 86367, 86480, 86923, 86960, 87209, 87900, 88333, 88334, 89049

Medicine
90760 – 90768, 90779, 91022, 92626, 92627, 92630, 92633, 95865, 95866, 95873, 95874, 96101, 96116, 96118, 96401, 96402, 96409, 96411, 96413, 96415 – 96417, 96521 – 96523, 99143 – 99150, 99304 – 99310, 99324 – 99328, 99334 – 99337

Please see **CPT-4/HCPCS**, *page 2*

CPT-4/HCPCS *(continued)*

HCPCS Level II Code Additions

Radiopharmaceuticals
A4641, A4642, A9500, A9502 – A9505, A9507, A9508, A9510, A9512, A9516, A9517, A9521, A9524, A9526, A9536 – A9567, A9600, A9605, A9698, A9699, C2634, C2635, C2637, Q9945 – Q9957

Surgery
C9724, C9725, S2068, S2075 – S2079, S2114, S2117

Injections and Drugs
A9535, C9225, J0132, J0133, J0135, J0278, J0480, J0795, J0881, J0882, J0885, J0886, J1162, J1265, J1451, J1640, J1675, J1751, J1752, J1945, J2278, J2325, J2425, J2503, J2504, J2805, J2850, J3285, J7306, J9175, J9225, J9264, Q0515, Q4079, S0145

Blood Factors
J7188, J7189

Cochlear Implant Lithium Batteries
L8623, L8624

Implantable Devices and Supplies
E0616, L8680 – L8689

Ventricular Assist Devices and Supplies
Q0480 – Q0505

CPT-4 Codes with Description Changes

Surgery
15000, 15001, 15100, 15101, 15120, 15121, 15200, 15240, 15260, 15400, 15401, 16020, 16025, 16030, 30130, 30140, 30801, 30930, 31520, 31525, 31526, 31530, 31531, 31535, 31536, 31540, 31541, 31560, 31561, 31570, 31571, 33502, 34833, 34834, 37209, 44202, 44310, 44320, 45119, 45540, 45550, 50688, 52647, 52648, 57421, 64613, 67901, 67902, 69725

Radiology
75900, 76012, 77412, 78608, 78609, 78811 – 78816

Pathology and Laboratory
82270, 83036, 83630, 83898, 83901, 84238, 86022, 86023, 86920 – 86922, 87534 – 87539, 87901 – 87904, 88175

Vaccines
90713

Medicine
90657, 90658, 90870, 90940, 91020, 92506, 92507, 92520, 92568, 92569, 96405, 96406, 96420, 96422, 96423, 97024, 97811, 97813, 97814

Please see **CPT-4/HCPCS**, *page 3*

CPT-4/HCPCS *(continued)*

HCPCS Level II Codes with Description Changes

Radiopharmaceuticals
A4641, A9528 – A9532

CPT-4 Code Deletions

Anesthesia
01964

Surgery
15342, 15343, 15350, 15351, 15810, 15811, 16010, 16015, 21493, 21494, 31585, 31586, 32520, 32522, 32525, 33918, 33919, 37720, 37730, 42325, 42326, 43638, 43639, 44200, 44201, 44239, 69410

Radiology
76375, 78160, 78162, 78170, 78172, 78455, 78990, 79900

Pathology and Laboratory
82273, 83715, 83716, 86064, 86379, 86585, 86587

Medicine
90780 – 90784, 90788, 90799, 90871, 90939, 92330, 92335, 92390 – 92393, 92325, 92396, 92510, 95858, 96100, 96115, 96117, 96400, 96408, 96410, 96412, 96414, 96520, 96530, 96545, 97020, 97504, 97520, 97703, 99052, 99054, 99141, 99142, 99261 – 99263, 99271 – 99275, 99301 – 99303, 99311 – 99313, 99321 – 99323, 99331 – 99333

HCPCS Level II Code Deletions

Radiopharmaceuticals
A4643 – A4647

Implantable Devices and Supplies
E0752, E0754, E0756 – E0759

California Temporary Codes
X1520, X6112, X6210, X6836, X7030, X7493, X7660, X7662

Pancreas Transplant Procedures Assigned Billing Codes

Effective retroactively for dates of service on or after January 1, 2005, pancreas transplants are a Medi-Cal benefit. Billing procedures have been established for pancreas procurement, pancreas transplant and removal of transplanted pancreatic allograft.

Timeliness Policy
Timeliness policy will be overridden through October 31, 2006. Claims submitted after October 31, 2006 are subject to the standard timeliness requirements. Providers who have already billed and received payment for the service will receive a Remittance Advice Details (RAD) code 010 denial for a duplicate claim. Re-billing must be done on a *Claims Inquiry Form* (CIF).

Please see **Pancreas Transplant**, *page 4*

Pancreas Transplant *(continued)*

Contract Inpatient Provider
Inpatient providers should bill pancreas transplants using the following combination of national revenue codes and ICD-9 procedure codes:

- Revenue code 201 (intensive care, surgical) or revenue code 203 (intensive care, pediatric)
- ICD-9 procedure code 52.80 (pancreatic transplant, not otherwise specified)

A *Treatment Authorization Request* (TAR) is required for these procedures and contract providers need to have negotiated the transplant with the California Medical Assistance Commission (CMAC).

Procurement
Inpatient providers procuring a pancreas may bill for the donor pancreatectomy using CPT-4 code 48550 (donor pancreatectomy, with preparation and maintenance of allograft from cadaver donor, with or without duodenal segment for transplantation). Providers should bill using a separate claim and their Outpatient provider number. A TAR is required for these procedures and an invoice from an Organ Procurement Organization (OPO) must be attached to the claim.

Physician Services
Physician services for the pancreas transplant should be billed using CPT-4 code 48554 (transplantation of pancreatic allograft). A TAR is required.

Removal of Transplanted Pancreatic Allograft
Providers may bill for the removal of a transplanted pancreas with CPT-4 code 48556 (removal of a transplanted pancreatic allograft). This code requires a TAR for the primary surgeon.

The updated information is reflected on manual replacement pages transplant 5, 7 and 12 (Part 2) and tar and non cd4 5 and 6 (Part 2).

Gastroesophageal Reflux Testing is New Benefit

Effective retroactively for dates of service on or after November 1, 2005, the following gastroesophageal reflux testing codes are Medi-Cal benefits.

CPT-4 Code	Description
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis and interpretation
91035	with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation
91038	prolonged (greater than 1 hour, up to 24 hours)
91040	Esophageal balloon distention provocation study

Codes 91034, 91035, 91037 and 91038 must be split-billed with modifier -26, -TC, -ZS or -99.

Note: Effective November 1, 2005 through July 31, 2006, providers should be retroactively reimbursed for appropriately billed claims that were denied for codes 91034 – 91040. No action is required by the provider.

A timeliness override, ending October 31, 2006, has been created for claims submitted for these services rendered for dates of service on November 1, 2005 through July 31, 2006. Providers must refer to the *UB-92 Submission and Timeliness Instructions* section for specific billing procedures.

This information is reflected on manual replacement pages medne 7 (Part 2) and tar and non cd9 1 (Part 2).

July 1, 2006 Vision Care Cut-Off Date for Proprietary and Non-HIPAA Standard Electronic Formats Reminder

On July 1, 2006, the California Department of Health Services (CDHS) discontinued the Vision CMC proprietary claims transaction format regardless of the date services were performed. All electronically submitted vision claims must now be in the HIPAA-compliant ASC X12N 837 v.4010A1 format. To bill vision services for dates of service on or after July 1, 2006, providers have the following three options.

Paper Claims
The option to bill by paper is available for CMC providers who were unable to convert to the 837 transaction format prior to July 1, 2006. In addition, because the *Payment Request for Vision Care and Appliances* (45-1) claim form was eliminated on July 1, 2006, paper claims with dates of service on or after July 1, 2006 must be billed on the *HCFA 1500* claim form. The 45-1 must be used for claims with dates of service prior to July 1, 2006. There is also a new 50-3 *Treatment Authorization Request* (TAR) form that must be used to request prior authorization for medically necessary contact lenses and services, low vision aids and non-PIA covered eye appliances for dates of service on or after July 1, 2006.

Electronic Claim Submission Using the Internet
Providers who successfully completed the *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153) and test claims may bill electronically on the HIPAA-compliant 837 transaction.

When converting to the 837 transaction, the Vision Data Specifications should be used for claims with dates of service prior to July 1, 2006. For dates of service on or after July 1, 2006, the Medical Data Specifications (part of the *837 v.4010A1 Health Care Claim Companion Guide*) has been updated to include the required segments for vision claims.

The companion guides are available on the *ASC X12N Version 4010A1 Companion Guides and NCPDP Technical Specifications* page of the Medi-Cal Web site.

Internet Professional Claims Submission
The HIPAA-compliant *837 Internet Professional Claim Submission (IPCS) Online Claim Form* has been updated and is available for claims with dates of service on or after July 1, 2006. The IPCS system gives vision care providers an alternate method of submitting electronic claims in real-time through the Medi-Cal Web site at **www.medi-cal.ca.gov**. Providers who successfully completed the *Medi-Cal Point of Service (POS) Network/Internet Agreement* and *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153) forms can bill using IPCS.

The IPCS system allows users to submit single vision service claims in real-time. The IPCS system does not perform online adjudication nor does it accept crossover claims. Claims submitted successfully receive a Claim Control Number (CCN) on the host response screen. If the IPCS system detects errors, the user will receive a "CLAIM REJECTED" message on the host response screen, and the claim can be edited to correct these errors before resubmitting. The IPCS system allows faster and more efficient data exchange between providers and CDHS.

Please refer to the *Internet Professional Claim Submission (IPCS) User Guide* for details about necessary forms and instructions.

Please see **Vision Care**, *page 6*

Vision Care *(continued)*

Electronic Attachments
Providers may now submit electronic 837 claims and fax their attachments. To use this new process, providers must be authorized to bill 837 v.4010A1 electronic claims. The fax process includes a *Medi-Cal Claim Attachment Control Form* (ACF), used as a coversheet for the supporting fax attachments. The ACF has a pre-printed Attachment Control Number (ACN) that submitters input on their electronic claim submission in the PWK segment of the transaction. Providers submit the electronic claim and fax the ACF along with the attachments to Medi-Cal. Each ACF and corresponding attachments require a separate fax call. Each call to the fax server must include one ACF as the first page followed by the attachment pages that correspond to that ACF. Additional ACFs and attachments must be sent as separate calls to the fax server. The number to fax attachments is 1-866-438-9377.

In addition to faxing them, providers may also mail hard copy attachments. Providers have a maximum of 30 calendar days from the date of claim submission to submit the supporting faxed or hard copy attachments. For information about how to send attachments, including the mailing address, providers may refer to the *Billing Instructions* section of the *837 Version 4010A1 Health Care Claim Companion Guide* on the Medi-Cal Web site.

Additional Resources
For more information, in-state providers may call the Telephone Service Center (TSC) at 1-800-541-5555, 8 a.m. to 5 p.m., Monday through Friday. Border providers, software vendors and out-of-state billers who bill for in-state providers should call (916) 636-1200.

CCS Service Code Groupings (SCG) Update

Retroactive for dates of service on or after July 1, 2004, a number of codes are added to the California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03 and 07.

In addition, code 99359 is end-dated for dates of service on or after July 1, 2006.

Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

The updated information is reflected on manual replacement pages cal child ser 5, 12 and 15 (Part 2).

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:
cal child ser 5/6, 11/12, 15/16
medne 7/8
tar and non cd4 5/6
tar and non cd8 1/2 *
tar and non cd9 1/2
transplant 5 thru 8, 11/12

* Pages updated due to ongoing provider manual revisions.